| CENTERS FOI | R MEDICARE & MEDIC                    | AID SERVICES                   |         |            |  | OW        | IB NO. 0938-0391 |
|-------------|---------------------------------------|--------------------------------|---------|------------|--|-----------|------------------|
| STATEMEN    | NT OF DEFICIENCIES                    | X1) PROVIDER/SUPPLIER/CLIA     | (X2) M  | ULTIPLE CO | ONSTRUCTION  | (X3) DATE | SURVEY           |
| AND PLAN    | OF CORRECTION                         | IDENTIFICATION NUMBER:         | - [.    |            | 00   | COMPI     | LETED            |
|             |                                       |                                | A. BUII |            | <u> </u>   | 08/01/2   | <sub>'011</sub>  |
|             |                                       |                                | B. WIN  |            |  | 33/31/2   |                  |
| NAME OF I   | PROVIDER OR SUPPLIEI                  | 2                              |         | STREET A   | ADDRESS, CITY, STATE, ZIP CODE                                     |           |                  |
| TWINE OF I  | RO VIDER OR SOIT EIE                  |                                |         | 607 WI     | LSON CREEK RD  |           |                  |
| PINE KN     | IOLL ASSISTED LIV                     | /ING CENTER                    |         | LAWRE      | ENCEBURG, IN47025  |           |                  |
| (V4) ID     | CUMMADV                               | ETATEMENT OF DEFICIENCIES      |         | ID.        | г  |           | (V5)             |
| (X4) ID     |                                       | STATEMENT OF DEFICIENCIES      |         | ID         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |           | (X5)             |
| PREFIX      |                                       | NCY MUST BE PERCEDED BY FULL   |         | PREFIX     | CROSS-REFERENCED TO THE APPROPRIA                                  | TE        | COMPLETION       |
| TAG         | REGULATORY OR                         | R LSC IDENTIFYING INFORMATION) |         | TAG        | DEFICIENCY)  |           | DATE             |
| R0000       |                                       |                                |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | This visit was fo                     | or the Investigation of        | RO      | 0000       |  |           |                  |
|             | Complaint IN00                        | <del>-</del>                   |         |            |  |           |                  |
|             | Complaint 11100                       | 093300.                        |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | Complaint IN00                        | 093566 - Substantiated.        |         |            |  |           |                  |
|             | A State Resident                      | tial deficiency related to     |         |            |  |           |                  |
|             | the allegation is                     |                                |         |            |  |           |                  |
|             | the anegation is                      | cited at Roz41.                |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | Survey date: Au                       | igust 1, 2011                  |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | Facility number:                      | 001142                         |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | Provider number                       |                                |         |            |  |           |                  |
|             | AIM number: 1                         | N/A                            |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | Survey team:                          |                                |         |            |  |           |                  |
|             | 1 *                                   | N                              |         |            |  |           |                  |
|             | Barbara Gray, R                       | .N                             |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | Census bed type                       | :                              |         |            |  |           |                  |
|             | Residential: 19                       |                                |         |            |  |           |                  |
|             | Residential. 17                       |                                |         |            |  |           |                  |
|             | _                                     |                                |         |            |  |           |                  |
|             | Census payor ty                       | pe:                            |         |            |  |           |                  |
|             | Other: 19                             |                                |         |            |  |           |                  |
|             | Total: 19                             |                                |         |            |  |           |                  |
|             | 10141. 17                             |                                |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | Sample: 3                             |                                |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | These state findi                     | ings are cited in              |         |            |  |           |                  |
|             | accordance with                       | _                              |         |            |  |           |                  |
|             | accordance with                       | 410 IAC 10.2.                  |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             | Quality review of                     | completed on August 3,         |         |            |  |           |                  |
|             | 2011 by Bev Fat                       | -                              |         |            |  |           |                  |
|             | ===================================== |                                |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |
|             |                                       |                                |         |            |  |           |                  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001142

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMEN                                      | T OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA  | (X2) M       | JLTIPLE CO   | NSTRUCTION   | (X3) DATE S      | SURVEY     |
|---|---|---|--------------|--|--|------------------|------------|
| AND PLAN                                      | OF CORRECTION   | IDENTIFICATION NUMBER:  | A. BUII      | DING   | 00   | COMPL            | ETED       |
|   |   |   | B. WIN       |  |  | 08/01/20         | 011        |
|   | ROVIDER OR SUPPLIER   |   | •            | 607 WIL  | ADDRESS, CITY, STATE, ZIP CODE<br>LSON CREEK RD<br>ENCEBURG, IN47025   |                  |            |
| (X4) ID                                       | SUMMARY S   | TATEMENT OF DEFICIENCIES  | ID<br>PREFIX |  | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)       |
| PREFIX  | *   | CY MUST BE PERCEDED BY FULL   |              |  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT  | E                | COMPLETION |
| TAG   |   | LSC IDENTIFYING INFORMATION) ation of medications and the                                 | 1            | TAG  | DEFICIENCY)  |                  | DATE       |
| R0241   | provision of reside<br>as ordered by the<br>shall be supervise<br>premises or on ca<br>(1) Medication sha | ential nursing care shall be<br>resident 's physician and<br>d by a licensed nurse on the |              |  |  |                  |            |
| Based on observation,                         |   |   | RO           | )241   | <ol> <li>Within five minutes of<br/>discovering that Resident A h<br/>received the wrong medication</li> </ol>                 |                  | 09/15/2011 |
|   | -   | and record  |              |  | LPN#1 faxed that information the resident's physician and  |                  |            |
|   | ŕ   | e facility failed   |              |  | contacted the family. The physician instructed LPN#1 to  | o                |            |
|   | to adminis  |   |              |  | monitor the resident's blood pressure and vital signs QID  |                  |            |
|   |   | ns according to   |              |  | 48 hours. Resident A was monitored QID for 48 hours v  |                  |            |
|   | 1 0   | cian's order and  |              |  | no negative results. The monitoring and results were   |                  |            |
|   | failed to o   | btain a   |              |  | entered into the resident's medical record. In regard to   | LPN              |            |
|   | physician'  | s order to hold   |              |  | #1's failure to obtain a physic<br>order to withhold Resident A'   | ian              |            |
|   | medicatio   | ns for 1 of 3   |              |  | ordered medications, LPN #1 resumed passing Resident A   |                  |            |
|   | residents s   | sampled for   |              |  | medication at the next sched med pass.2. All residents ha  | uled             |            |
|   | medicatio   | ns. (Resident   |              |  | the potential to be effected by med pass error. The current  | y a              |            |
| #A) Findings include: Resident A's record was |   |   |              |  | method used by this facility h<br>been in place for many years<br>without error. On August 4, 2<br>the Administrator performed | nas<br>;<br>011, |            |
|   |   |   |              | one-on-one inservice with LF reviewing the cause of the medication error, policies and procedures regarding medication | 'N#1,<br>d   |                  |            |
|   |   |   |              | passes and the requirement obtaining physician orders in order to hold medications.3.                                  | of   |                  |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | LDING   | NSTRUCTION  00      | (X3) DATE S<br>COMPL<br>08/01/2   | ETED  |                            |
|--|--|--|---|---------------------|---|---|----------------------------|
|  | PROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE 607 WILSON CREEK RD LAWRENCEBURG, IN47025 |                     |   |   |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | NTE   | (X5)<br>COMPLETION<br>DATE |
| TAG  | reviewed 10:42 A.N included be limited to atrial fibric (irregular aseptic new hips, ischeright femula bowel syngastroesop disease, deanxiety.  A July, 20 recapitula Resident # the follows 1.) Fentantial fibric femula fibric follows 1.) Fentantial fibric femula fibric | on 8/1/11 at  1. Diagnoses out were not hypertension, llation heart rhythm), crosis of both emic necrosis ar, irritable drome, chageal reflux epression, and  11, physician's tion order for A indicated ing orders: |   | TAG                 | all-nursing inservice regarding same topics reviewed with Livill be held by the Administry on August 17, 2011. Also, at time of the medication counting the end of each shift the inconurse will complete a medic count form to demonstrate the counts were correct or the there were discrepancies in count. If a discrepancy occumust be accounted for by the outgoing nurse with a detailed explanation. A copy of each medication count will be proto the Administrator for a period of four (4) consecutive week discrepancies will be discussed by the Administrator and the nurses involved in the counting the results of all medication courting the results of all medication courting the four (4) week period, will randomly review subsequences. | ng the IPN#1 ator at the t at oming ation hat hat the urs, it e ed i vided riod as. All sed4. | DATE                       |
|  |  |  |   |                     |   |   |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      | A. BUII   | LDING  | NSTRUCTION  00      | (X3) DATE S<br>COMPL<br>08/01/2  | ETED |                            |
|---|----------------------|---|--------|---------------------|--|------|----------------------------|
|   | PROVIDER OR SUPPLIER |   | B. WIN | STREET A            | DDRESS, CITY, STATE, ZIP CODE<br>SON CREEK RD<br>NCEBURG, IN47025  |      |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | πE   | (X5)<br>COMPLETION<br>DATE |
|   | (pain med            | ication). 1   |        |                     |  |      |                            |
|   | patch topi           | cally, changed  |        |                     |  |      |                            |
|   | every other          | er day with 25  |        |                     |  |      |                            |
|   | meg patch            | to = $125 \text{ mcg}$ .  |        |                     |  |      |                            |
|   | 2.) Fentai           | nyl 25 mcg/hr   |        |                     |  |      |                            |
|   | patch. 1 p           | oatch topically,  |        |                     |  |      |                            |
|   | changed e            | very other day  |        |                     |  |      |                            |
|   | with 100 1           | mcg patch to =  |        |                     |  |      |                            |
|   | 125 mcg.             |   |        |                     |  |      |                            |
|   | 3.) Lisino           | pril 10   |        |                     |  |      |                            |
|   | milligram            | (mg) - 1 tablet   |        |                     |  |      |                            |
|   | by mouth             | daily at 8:00   |        |                     |  |      |                            |
|   | A.M. for 1           | nigh blood  |        |                     |  |      |                            |
|   | pressure.            | 4.) Metamucil   |        |                     |  |      |                            |
|   | - mix 15 r           | nilliliters (ml)  |        |                     |  |      |                            |
|   | with liqui           | d and take by   |        |                     |  |      |                            |
|   | mouth dai            | ly at 8:00 A.M.   |        |                     |  |      |                            |
|   | (fiber laxa          | ative).   |        |                     |  |      |                            |
|   | 5.) Venla            | faxine capsule  |        |                     |  |      |                            |
|   | ER - 150 1           | mg daily at   |        |                     |  |      |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      | A. BUILDING   |   | NSTRUCTION  00 | (X3) DATE:<br>COMPL<br>08/01/2   | ETED |                            |
|---|----------------------|---|---|----------------|--|------|----------------------------|
|   | PROVIDER OR SUPPLIER |   | STREET ADDRESS, CITY, STATE, ZIP CODE  607 WILSON CREEK RD  LAWRENCEBURG, IN47025 |                |  |      |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG   |                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ΤE   | (X5)<br>COMPLETION<br>DATE |
|   | 8:00 A.M             | •   |   |                |  |      |                            |
|   | (anti-depr           | essant)   |   |                |  |      |                            |
|   | 6.) Vitam            | in E capsule -  |   |                |  |      |                            |
|   | 400 units            | - take 2  |   |                |  |      |                            |
|   | capsules b           | y mouth daily   |   |                |  |      |                            |
|   | at 8:00 A.           | M.  |   |                |  |      |                            |
|   | 7.) Digox            | in 0.125 mg   |   |                |  |      |                            |
|   | tablet by 1          | nouth daily at  |   |                |  |      |                            |
|   | 8:00 A.M             | check pulse.  |   |                |  |      |                            |
|   | (cardiac n           | nedication)   |   |                |  |      |                            |
|   | 8.) Calciu           | m with vitamin  |   |                |  |      |                            |
|   | D 600 mg             | - take 1 tablet   |   |                |  |      |                            |
|   | by mouth             | 2 times a day   |   |                |  |      |                            |
|   | at 8:00 A.           | M., and 5:00  |   |                |  |      |                            |
|   | P.M.                 |   |   |                |  |      |                            |
|   | 9.) Colac            | e 100 mg  |   |                |  |      |                            |
|   | capsule - 1          | take 1 capsule  |   |                |  |      |                            |
|   | 2 times a            | day at 8:00   |   |                |  |      |                            |
|   |                      | 5:00 P.M.   |   |                |  |      |                            |
|   | (stool soft          |   |   |                |  |      |                            |
|   |                      |   |   |                |  |      |                            |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      |  | (X2) MULTIPLE CO | ONSTRUCTION  | (X3) DATE SURVEY   |
|--|----------------------|--|------------------|--|--------------------|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER:                                   | A. BUILDING      | 00   | COMPLETED          |
|  |                      |  | B. WING          |  | 08/01/2011         |
| NAME OF I  | PROVIDER OR SUPPLIER |  | l                | ADDRESS, CITY, STATE, ZIP CODE                                     |                    |
| PINE KN  | OLL ASSISTED LIV     | ING CENTER   | l                | LSON CREEK RD<br>ENCEBURG, IN47025                                 |                    |
| (X4) ID  |                      | TATEMENT OF DEFICIENCIES                                 | ID               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE | (X5)               |
| PREFIX<br>TAG  | · ·                  | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG    | CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)                     | TE COMPLETION DATE |
|  |                      |  |                  |  |                    |
|  | Nurses no            | ites for   |                  |  |                    |
|  |                      | AA indicated   |                  |  |                    |
|  |                      | ring: "7/12/11   |                  |  |                    |
|  |                      | M I was  |                  |  |                    |
|  | passing m            |  |                  |  |                    |
|  | 1                    | · ·  |                  |  |                    |
|  |                      | ns that I had  |                  |  |                    |
|  | set up in t          | he medication  |                  |  |                    |
|  | room, alo            | ng with other  |                  |  |                    |
|  | residents'           | medications.   |                  |  |                    |
|  | All medic            | ations were set  |                  |  |                    |
|  | up with m            | ed cards in the  |                  |  |                    |
|  | tray with            | a list of  |                  |  |                    |
|  | medicatio            | ns the residents   |                  |  |                    |
|  | take. I gra          | abbed the cup  |                  |  |                    |
|  | of medica            | tions I thought  |                  |  |                    |
|  | were Resi            | dent #A's and  |                  |  |                    |
|  | gave them            | to her. Then I   |                  |  |                    |
|  | went back            | into the   |                  |  |                    |
|  | medicatio            | n room to  |                  |  |                    |
|  |                      |  |                  |  |                    |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                         | (X2) MU<br>A. BUIL<br>B. WING   | DING  | NSTRUCTION 00       | (X3) DATE:<br>COMPL<br>08/01/2   | ETED |                            |
|---|-------------------------|---|---|---------------------|--|------|----------------------------|
|   | PROVIDER OR SUPPLIER    |   | STREET ADDRESS, CITY, STATE, ZIP CODE 607 WILSON CREEK RD LAWRENCEBURG, IN47025 |                     |  |      |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN          | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION) |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ATE  | (X5)<br>COMPLETION<br>DATE |
|   | finish my other         |   |   |                     |  |      |                            |
|   | medication passes and   |   |   |                     |  |      |                            |
|   | realized R              | lesident #A's   |   |                     |  |      |                            |
|   | medicatio               | ns were still in  |   |                     |  |      |                            |
|   | the tray.               | I realized I had  |   |                     |  |      |                            |
|   | given Res               | ident #A the  |   |                     |  |      |                            |
|   | wrong me                | dications."   |   |                     |  |      |                            |
|   |                         |   |   |                     |  |      |                            |
|   | A fax mes               | sage to the   |   |                     |  |      |                            |
|   | physician               | for Resident  |   |                     |  |      |                            |
|   | #A dated                | 7/12/11 at 9:15   |   |                     |  |      |                            |
|   | A.M., ind               | icated the  |   |                     |  |      |                            |
|   | following               | : "I gave   |   |                     |  |      |                            |
|   | Resident #              | #A another  |   |                     |  |      |                            |
|   | resident's              | medications.  |   |                     |  |      |                            |
|   | They were               | e Aspirin 81  |   |                     |  |      |                            |
|   | _                       | zem 180 mg  |   |                     |  |      |                            |
|   | cardiovas               | •   |   |                     |  |      |                            |
|   | medication], potassium  |   |   |                     |  |      |                            |
|   | chloride 20 meq, Celexa |   |   |                     |  |      |                            |
|   |                         |   |   |                     |  |      |                            |

001142

|                   |                            | IDENTIFICATION NUMBER:                                |        | ULTIPLE CON<br>LDING | 00                                |   | (X3) DATE S<br>COMPL | ETED               |
|-------------------|----------------------------|---|--------|----------------------|-----------------------------------|---|----------------------|--------------------|
|                   |                            |   | B. WIN |                      |                                   |   | 08/01/2              | 011                |
| NAME OF P         | ROVIDER OR SUPPLIER        |   |        |                      | DDRESS, CITY, STA<br>SON CREEK RI | •                                       |                      |                    |
| PINE KN           | OLL ASSISTED LIV           | ING CENTER  |        | 1                    | NCEBURG, IN4                      |   |                      |                    |
| (X4) ID<br>PREFIX |                            | TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL |        | ID<br>PREFIX         |                                   | LAN OF CORRECTION<br>E ACTION SHOULD BE |                      | (X5)<br>COMPLETION |
| TAG               | *                          | LSC IDENTIFYING INFORMATION)                          |        | TAG                  |                                   | D TO THE APPROPRIAT<br>CIENCY)          | E                    | DATE               |
|                   | 10 mg [an                  | ti-depressant],                                       |        |                      |                                   |   |                      |                    |
|                   | Centrum S                  | Silver tablet,  |        |                      |                                   |   |                      |                    |
|                   | Avapro 30                  | 00 mg   |        |                      |                                   |   |                      |                    |
|                   | [anti-hype                 | ertensive],   |        |                      |                                   |   |                      |                    |
|                   | HCTZ 25                    | mg  |        |                      |                                   |   |                      |                    |
|                   | [diuretic-a                | intihypertensiv                                       |        |                      |                                   |   |                      |                    |
|                   | e], Vitami                 | n D 1,000   |        |                      |                                   |   |                      |                    |
|                   | units, and                 | oyster shell  |        |                      |                                   |   |                      |                    |
|                   | calcium w                  | rith vitamin D  |        |                      |                                   |   |                      |                    |
|                   | 500 mg. V                  | What do I need  |        |                      |                                   |   |                      |                    |
|                   | to watch f                 | or?" A return   |        |                      |                                   |   |                      |                    |
|                   | fax messa                  | ge from the   |        |                      |                                   |   |                      |                    |
|                   | physicians                 | soffice   |        |                      |                                   |   |                      |                    |
|                   | indicated 1                | the following   |        |                      |                                   |   |                      |                    |
|                   | response.                  | "Monitor the  |        |                      |                                   |   |                      |                    |
|                   | patient's b                | lood pressure   |        |                      |                                   |   |                      |                    |
|                   | and vital s                | signs QID (4  |        |                      |                                   |   |                      |                    |
|                   | times a da                 | y) for 48   |        |                      |                                   |   |                      |                    |
|                   | hours."                    |   |        |                      |                                   |   |                      |                    |
|                   |                            |   |        |                      |                                   |   |                      |                    |
| FORM CMS-2        | 567(02-99) Previous Versio | ns Obsolete Event ID:                                 | PM0I11 | Facility II          | D: 001142                         | If continuation sl                      | neet Pag             | ge 8 of 16         |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                         |   | IULTIPLE CO<br>LDING | INSTRUCTION 00      | (X3) DATE   |         |                            |
|---|-------------------------|---|----------------------|---------------------|---|---------|----------------------------|
|   |                         |   | B. WIN               | IG                  |   | 08/01/2 | 011                        |
| NAME OF I   | PROVIDER OR SUPPLIER    |   |                      | 1                   | ADDRESS, CITY, STATE, ZIP CODE<br>LSON CREEK RD   |         |                            |
|   | OLL ASSISTED LIV        |   |                      |                     | NCEBURG, IN47025  |         |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN          | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE     | (X5)<br>COMPLETION<br>DATE |
|   | An intervi              | iew with LPN  |                      |                     |   |         |                            |
|   | #1 on 8/1/              | '11 at 11:18  |                      |                     |   |         |                            |
|   | A.M., ind               | icated she set  |                      |                     |   |         |                            |
|   | up her mo               | rning   |                      |                     |   |         |                            |
|   | medicatio               | n pass on   |                      |                     |   |         |                            |
|   | 7/12/11, ii             | n a tray with a   |                      |                     |   |         |                            |
|   | medicatio               | n card behind   |                      |                     |   |         |                            |
|   | each resid              | ent's   |                      |                     |   |         |                            |
|   | medicatio               | n, listing the  |                      |                     |   |         |                            |
|   | medicatio               | ns each   |                      |                     |   |         |                            |
|   | resident sl             | hould receive.  |                      |                     |   |         |                            |
|   | LPN # 1 i               | ndicated she  |                      |                     |   |         |                            |
|   | was not su              | are how   |                      |                     |   |         |                            |
|   | Resident #              | A received  |                      |                     |   |         |                            |
|   | another re              | sident's  |                      |                     |   |         |                            |
|   | medicatio               | n. LPN #1   |                      |                     |   |         |                            |
|   | indicated she must have |   |                      |                     |   |         |                            |
|   | been hurry              | ying when she   |                      |                     |   |         |                            |
|   | gave Resi               | dent #A   |                      |                     |   |         |                            |
|   | another re              | esident's   |                      |                     |   |         |                            |
|   |                         |   |                      |                     |   |         |                            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                            | (X2) MI   | JLTIPLE CON | NSTRUCTION   |                                    | (X3) DATE :<br>COMPL                 |          |                    |
|--|----------------------------|---|-------------|--------------|------------------------------------|--------------------------------------|----------|--------------------|
| AND PLAN   | OF CORRECTION              | IDENTIFICATION NUMBER:                                | A. BUII     |              | 00                                 |                                      | 08/01/2  |                    |
|  |                            |   | B. WIN      |              | DDRESS, CITY, STAT                 | E, ZIP CODE                          |          |                    |
| NAME OF F  | PROVIDER OR SUPPLIER       |   |             |              | SON CREEK RE                       |                                      |          |                    |
| PINE KN  | OLL ASSISTED LIV           | ING CENTER  |             | LAWRE        | NCEBURG, IN47                      | 7025                                 |          |                    |
| (X4) ID<br>PREFIX  |                            | TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL |             | ID<br>PREFIX | PROVIDER'S PLA<br>(EACH CORRECTIVE | AN OF CORRECTION<br>ACTION SHOULD BE |          | (X5)<br>COMPLETION |
| TAG  | *                          | LSC IDENTIFYING INFORMATION)                          |             | TAG          |                                    | ) TO THE APPROPRIAT<br>TENCY)        | E        | DATE               |
|  | medication                 | ns.   |             |              |                                    |                                      |          |                    |
|  |                            |   |             |              |                                    |                                      |          |                    |
|  | An intorvi                 | lew with LPN  |             |              |                                    |                                      |          |                    |
|  |                            |   |             |              |                                    |                                      |          |                    |
|  | #1 on 8/1/                 | '11 at 4:42   |             |              |                                    |                                      |          |                    |
|  | P.M., indi                 | cated she held  |             |              |                                    |                                      |          |                    |
|  | all of Resi                | ident #A's 8:00                                       |             |              |                                    |                                      |          |                    |
|  | A.M., med                  | dications on  |             |              |                                    |                                      |          |                    |
|  | 7/12/11, e                 | xcept Resident  |             |              |                                    |                                      |          |                    |
|  | #A's two l                 | Fentanyl  |             |              |                                    |                                      |          |                    |
|  | patches ar                 | nd her  |             |              |                                    |                                      |          |                    |
|  | Metamuci                   | 1. LPN #1   |             |              |                                    |                                      |          |                    |
|  | indicated s                | she began   |             |              |                                    |                                      |          |                    |
|  | dispensing                 | g Resident #A   |             |              |                                    |                                      |          |                    |
|  | routine sc                 | heduled   |             |              |                                    |                                      |          |                    |
|  | medication                 | ns again at her                                       |             |              |                                    |                                      |          |                    |
|  | 12 noon m                  | nedication pass.                                      |             |              |                                    |                                      |          |                    |
|  | LPN #1 in                  | ndicated she  |             |              |                                    |                                      |          |                    |
|  | did not red                | ceive an order  |             |              |                                    |                                      |          |                    |
|  | to hold Re                 | esident #A's  |             |              |                                    |                                      |          |                    |
|  | 8:00 A.M.                  | ., medications.                                       |             |              |                                    |                                      |          |                    |
|  |                            |   |             |              |                                    |                                      |          |                    |
| FORM CMS-2   | 567(02-99) Previous Versio | ns Obsolete Event ID:                                 | PM0I11      | Facility II  | D: 001142                          | If continuation sh                   | neet Par | ge 10 of 16        |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      |   |        | NSTRUCTION<br>00    | (X3) DATE<br>COMPL  |         |                            |
|---|----------------------|---|--------|---------------------|---|---------|----------------------------|
|   |                      |   | B. WIN | LDING<br>G          |   | 08/01/2 | 011                        |
| NAME OF I   | PROVIDER OR SUPPLIER | 1   |        |                     | DDRESS, CITY, STATE, ZIP CODE  SON CREEK RD   |         |                            |
| PINE KN   | OLL ASSISTED LIV     | ING CENTER  |        | LAWRE               | NCEBURG, IN47025  |         |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN       | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | ATE     | (X5)<br>COMPLETION<br>DATE |
|   | LPN #1 ir            | ndicated she  |        |                     |   |         |                            |
|   | did not re           | ceive any   |        |                     |   |         |                            |
|   | clarification        | on on what  |        |                     |   |         |                            |
|   | medicatio            | ns should be  |        |                     |   |         |                            |
|   | held or res          | sumed for   |        |                     |   |         |                            |
|   | Resident #           | #A, after   |        |                     |   |         |                            |
|   | receiving            | another   |        |                     |   |         |                            |
|   | resident's           | medication on   |        |                     |   |         |                            |
|   | 7/12/11. 1           | LPN #1  |        |                     |   |         |                            |
|   | indicated            | she made the  |        |                     |   |         |                            |
|   | choice on            | her own to  |        |                     |   |         |                            |
|   | hold most            | of Resident   |        |                     |   |         |                            |
|   | #A's routi           | ne 8:00 A.M.,   |        |                     |   |         |                            |
|   | medicatio            | ns. LPN # 1   |        |                     |   |         |                            |
|   | indicated            | she should  |        |                     |   |         |                            |
|   | have obtain          | ined a  |        |                     |   |         |                            |
|   | physician'           | s clarification   |        |                     |   |         |                            |
|   | to hold or           | administer  |        |                     |   |         |                            |
|   | Resident #           | #A's  |        |                     |   |         |                            |
|   | medicatio            | ns on 7/12/11,  |        |                     |   |         |                            |
|   |                      |   |        |                     |   |         |                            |

001142

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING   | ONSTRUCTION  00     | li i   | e survey<br>pleted<br>/2011 |                      |
|---|---|--|---------------------|--|-----------------------------|----------------------|
|   | PROVIDER OR SUPPLIER  |  | STREET 607 W        | ADDRESS, CITY, STATE, ZIP COD<br>ILSON CREEK RD<br>ENCEBURG, IN47025                                   | E                           |                      |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | JLD BE                      | (X5) COMPLETION DATE |
|   | after givin   | g Resident #A  |                     |  |                             |                      |
|   | another re  | sident's   |                     |  |                             |                      |
|   | medicatio   | ns.  |                     |  |                             |                      |
|   | for a media 8/1/11 at 1 Two cups containing medication set up in containing a card behavith each name, roophysician's of the medical card behavith each name. | ns each were rups on a tray. eation cups had aind each cup resident's m number, s name, name dications the vas to receive, |                     |  |                             |                      |
|   |   | ns were due.   |                     |  |                             |                      |

| <b>i</b> '                        |  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION  00 |   |  | (X3) DATE SURVEY<br>COMPLETED |                    |  |
|-----------------------------------|--|--|--------------------------------|---|--|-------------------------------|--------------------|--|
|                                   |  |  | - 1                            | A. BUILDING B. WING   |  |                               | 08/01/2011         |  |
| NAME OF PROVIDER OR SUPPLIER      |  |  |                                | 1   | ADDRESS, CITY, STATE, ZIP CODE                   |                               |                    |  |
| PINE KNOLL ASSISTED LIVING CENTER |  |  |                                | 1   | LSON CREEK RD<br>ENCEBURG, IN47025               |                               |                    |  |
| (X4) ID                           | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION) |  |                                | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE |  |                               | (X5)               |  |
| PREFIX<br>TAG                     |  |  |                                | TAG   | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | JΈ                            | COMPLETION<br>DATE |  |
|                                   | Two medi   | cine cups of   |                                |   |  |                               |                    |  |
|                                   | applesauc  | e were also on                                       |                                |   |  |                               |                    |  |
|                                   | the tray. I  | LPN #1 took  |                                |   |  |                               |                    |  |
|                                   | _  | fmedications   |                                |   |  |                               |                    |  |
|                                   | to the dini  | ng room,   |                                |   |  |                               |                    |  |
|                                   | placed the medications   |  |                                |   |  |                               |                    |  |
|                                   | in the applesauce one at   |  |                                |   |  |                               |                    |  |
|                                   | a time, and handed both  |  |                                |   |  |                               |                    |  |
|                                   | residents their  |  |                                |   |  |                               |                    |  |
|                                   | medication   | ns one at a  |                                |   |  |                               |                    |  |
|                                   | time. Bot  | h residents  |                                |   |  |                               |                    |  |
|                                   | took the medications,  |  |                                |   |  |                               |                    |  |
|                                   | dipped the medications   |  |                                |   |  |                               |                    |  |
|                                   | out of the applesauce  |  |                                |   |  |                               |                    |  |
|                                   | with a spoon, and took   |  |                                |   |  |                               |                    |  |
|                                   | their medi   | cations  |                                |   |  |                               |                    |  |
|                                   | without ar   | ny problems.   |                                |   |  |                               |                    |  |
|                                   |  |  |                                |   |  |                               |                    |  |
|                                   | LPN #1 w   | as observed  |                                |   |  |                               |                    |  |
|                                   | for medica   | ation pass on  |                                |   |  |                               |                    |  |
|                                   |  |  |                                |   |  |                               |                    |  |

|                                   |   | IDENTIFICATION NUMBER:       | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  00  |  |                    | (X3) DATE SURVEY  COMPLETED    |            |             |
|-----------------------------------|---|------------------------------|--|--|--------------------|--------------------------------|------------|-------------|
|                                   |   |                              | 1 ' '  | B. WING  |                    |                                | 08/01/2011 |             |
| NAME OF PROVIDER OR SUPPLIER      |   |                              | -  |  | DDRESS, CITY, STAT |                                |            |             |
| PINE KNOLL ASSISTED LIVING CENTER |   |                              | 607 WILSON CREEK RD<br>LAWRENCEBURG, IN47025 |  |                    |                                |            |             |
| (X4) ID<br>PREFIX                 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL |                              |  | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL |                    |                                |            |             |
| TAG                               | `   | LSC IDENTIFYING INFORMATION) |  | TAG  |                    | D TO THE APPROPRIAT<br>CIENCY) | ΓE         | DATE        |
|                                   | 8/1/11 at 1   | 1:58 P.M. LPN                |  |  |                    |                                |            |             |
|                                   | #2 set up s   | six residents'               |  |  |                    |                                |            |             |
|                                   | medication  | ns in cups and               |  |  |                    |                                |            |             |
|                                   | placed the  | em in a tray.                |  |  |                    |                                |            |             |
|                                   | The medic   | cation cups had              |  |  |                    |                                |            |             |
|                                   | a card beh  | aind each cup                |  |  |                    |                                |            |             |
|                                   | with each resident's  |                              |  |  |                    |                                |            |             |
|                                   | name, room number,  |                              |  |  |                    |                                |            |             |
|                                   | physician's name, the   |                              |  |  |                    |                                |            |             |
|                                   | name of the medications   |                              |  |  |                    |                                |            |             |
|                                   | the resider   | nt was to                    |  |  |                    |                                |            |             |
|                                   | receive, an   | nd the time the              |  |  |                    |                                |            |             |
|                                   | medications were due.   |                              |  |  |                    |                                |            |             |
|                                   | Six cups of water and   |                              |  |  |                    |                                |            |             |
|                                   | one small medicine cup  |                              |  |  |                    |                                |            |             |
|                                   | with apple  | esauce were set              |  |  |                    |                                |            |             |
|                                   | on the tray   | y. LPN #1                    |  |  |                    |                                |            |             |
|                                   | carried the   | e tray to each               |  |  |                    |                                |            |             |
|                                   | resident's  | room and                     |  |  |                    |                                |            |             |
|                                   | dispensed   | each resident                |  |  |                    |                                |            |             |
| FORM CMS-2                        | 567(02-99) Previous Versio  | ns Obsolete Event ID:        | <br>PM0I11                                   | Facility I   | D: 001142          | If continuation sl             | heet Pa    | ge 14 of 16 |

Page 14 of 16

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  00 |         |                     | (X3) DATE SURVEY  COMPLETED  |                 |  |  |
|---|--|---|---------|---------------------|--|-----------------|--|--|
|   |  |   | B. WING |                     |  | 08/01/2011      |  |  |
| NAME OF PROVIDER OR SUPPLIER  |  |   |         | 1                   | ADDRESS, CITY, STATE, ZIP CODE  LSON CREEK RD  |                 |  |  |
| PINE KNOLL ASSISTED LIVING CENTER   |  |   |         | LAWRE               | NCEBURG, IN47025   |                 |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION) |   |         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | ON SHOULD BE CO |  |  |
|   | their medi   | ication off of                              |         |                     |  |                 |  |  |
|   | the tray.  | All six                                     |         |                     |  |                 |  |  |
|   | residents t  | took their                                  |         |                     |  |                 |  |  |
|   | medication   | ns without any                              |         |                     |  |                 |  |  |
|   | problems.  | An interview                                |         |                     |  |                 |  |  |
|   | with LPN #1 on 8/1/11  |   |         |                     |  |                 |  |  |
|   | at 2:30 P.M., indicated  |   |         |                     |  |                 |  |  |
|   | the facility had used this   |   |         |                     |  |                 |  |  |
|   | medication pass  |   |         |                     |  |                 |  |  |
|   | procedure since she had  |   |         |                     |  |                 |  |  |
|   | worked at  | the facility.                               |         |                     |  |                 |  |  |
|   | LPN #1 indicated she   |   |         |                     |  |                 |  |  |
|   | had worked at the  |   |         |                     |  |                 |  |  |
|   | facility for 14 years.   |   |         |                     |  |                 |  |  |
|   |  |   |         |                     |  |                 |  |  |
|   | This state residential   |   |         |                     |  |                 |  |  |
|   | finding re   | lates to                                    |         |                     |  |                 |  |  |
|   | Complain   | t IN00093566.                               |         |                     |  |                 |  |  |
|   |  |   |         |                     |  |                 |  |  |
|   |  |   |         |                     |  |                 |  |  |
|   |  |   |         |                     |  |                 |  |  |

001142

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                | (X2) MULTIPLE CO  A. BUILDING  B. WING  | 00  | COM  | (X3) DATE SURVEY COMPLETED 08/01/2011 |                            |  |  |  |
|---|----------------|---|---|--|---------------------------------------|----------------------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER PINE KNOLL ASSISTED LIVING CENTER                                      |                |   | STREET ADDRESS, CITY, STATE, ZIP CODE 607 WILSON CREEK RD LAWRENCEBURG, IN47025 |  |                                       |                            |  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | HOULD BE                              | (X5)<br>COMPLETION<br>DATE |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |
|   |                |   |   |  |                                       |                            |  |  |  |